NORTH TEXAS INFUSION CENTERS

Entyvio® (vidolizumab) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)
3. Hepatitis B vaccine or testing documentation

_____ _____
Patient Name **DOB**

_____ _____ _____ _____
Height **Weight** **Allergies** **Patient Phone**

Diagnosis (must include ICD 10 code)
☐Crohn's Disease _____
☐Ulcerative Colitis_____

Prescription Orders: Entyvio® (vidolizumab)

☐ **Initial Dosing:** Give Entyvio 300mg (20 mL vial) diluted in 250mL NS and infuse over 30 minutes as tolerated. Give at day 0, 2 weeks, 6 weeks and then every 8 weeks.
☐ **Renewal Dosing:** Give Entyvio 300mg (20 mL vial) diluted in 250mL NS and infuse over 30 minutes as tolerated every _____ weeks.

Pre-Medications:
☐ Acetaminophen 650mg PO ☐ Benadryl 25 mg IVP ☐ Solu-Medrol 40mg IVP
☐ Benadryl 50 mg IVP ☐ Solu-Medrol 120 mg IVP
☐ Other _____

Standing Lab Orders: ☐ CMP ☐ CBC ☐ ESR ☐ CRP ☐ Other:_____every infusion
Refills: ☐ 12 months or ☐ _____ infusions

_____
Physician Name **Phone** **Fax**

_____
Physician's signature **Date**

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com